FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039636

Facility Name: Cahokia Nursing and Rehabilitation Center

Address: 2 Annabelle Court (Number) Cahokia (City) 62206 (Zip Code)

County: St. Clair

Telephone Number: (618) 332-0114 **Fax #** (618) 332-1043

IDPA ID Number: 363952442001

Date of Initial License for Current Owners: 06/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-4580
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,804	33	4,594	9,431	8
9	SNF/PED					9
10	ICF	30,957	325	58	31,340	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,761	358	4,652	40,771	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.26%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 3,929

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	192,891	15,463	3,600	211,954		211,954		211,954			1
2	Food Purchase		159,595		159,595		159,595	8,705	168,300			2
3	Housekeeping	133,997	66,420		200,417		200,417	85	200,502			3
4	Laundry	57,650	23,434		81,084		81,084		81,084			4
5	Heat and Other Utilities			110,809	110,809		110,809	1,859	112,668			5
6	Maintenance	35,726	59,080	9,475	104,281		104,281	528	104,809			6
7	Other (specify):*											7
8	**TOTAL General Services**	420,264	323,992	123,884	868,140		868,140	11,177	879,317			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,448,460	32,749	8,318	1,489,527		1,489,527	(4,726)	1,484,801			10
10a	Therapy			372,817	372,817		372,817		372,817			10a
11	Activities	65,637	5,557		71,194		71,194		71,194			11
12	Social Services	27,071			27,071		27,071		27,071			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,541,168	38,306	385,935	1,965,409		1,965,409	(4,726)	1,960,683			16
	C. General Administration											
17	Administrative	118,807		243,250	362,057		362,057	(127,895)	234,162			17
18	Directors Fees											18
19	Professional Services			65,745	65,745		65,745	20,815	86,560			19
20	Dues, Fees, Subscriptions & Promotions			9,779	9,779		9,779	44	9,823			20
21	Clerical & General Office Expenses	279,268		39,174	318,442		318,442	69,943	388,385			21
22	Employee Benefits & Payroll Taxes			317,306	317,306		317,306	3,012	320,318			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,638	1,638		1,638	78	1,716			24
25	Other Admin. Staff Transportation			5,196	5,196		5,196	265	5,461			25
26	Insurance-Prop.Liab.Malpractice			16,832	16,832		16,832	1,258	18,090			26
27	Other (specify):* **Mgmt Co. Benefits**							13,673	13,673			27
28	**TOTAL General Administration**	398,075		698,920	1,096,995		1,096,995	(18,807)	1,078,188			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,359,507	362,298	1,208,739	3,930,544		3,930,544	(12,356)	3,918,188			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center #0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			37,536	37,536		37,536	184,044	221,580			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,523	32,523		32,523	265,990	298,513			32
33	Real Estate Taxes							164,137	164,137			33
34	Rent-Facility & Grounds			600,000	600,000		600,000	(600,000)				34
35	Rent-Equipment & Vehicles			1,783	1,783		1,783	1,391	3,174			35
36	Other (specify):* Mortgage Ins.							19,382	19,382			36
37	**TOTAL Ownership**			671,842	671,842		671,842	34,944	706,786			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		122,795	1,384	124,179		124,179	(12,730)	111,449			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,350	82,350		82,350		82,350			42
43	Other (specify):* Nonallowable Costs			91,301	91,301		91,301	(91,301)				43
44	**TOTAL Special Cost Centers**		122,795	175,035	297,830		297,830	(104,031)	193,799			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,359,507	485,093	2,055,616	4,900,216		4,900,216	(81,443)	4,818,773			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,223)	30		9
10	Interest and Other Investment Income	892	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(244)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(78,921)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,376)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,943)	43		24
25	Fund Raising, Advertising and Promotional	(887)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(10,358)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (123,060)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	41,617		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 41,617		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (81,443)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Cahokia Nursing and Rehabilitation Center

ID# 0039636

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chamber of Commerce dues	$ (50)	20	1
2	Interest income offset	(1,002)	32	2
3	Medicare lab	(6,258)	43	3
4	Medicare xray	(2,920)	43	4
5	Political contributions	(128)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,358)		49

Cahokia Nursing and Rehabilitation Center
Provider #: 0039636
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	45	11,672	0	0	0	0	0	0	0	11,717	2
3	Housekeeping	0	0	85	0	0	0	0	0	0	0	0	85	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,859	0	0	0	0	0	0	0	0	1,859	5
6	Maintenance	0	0	528	0	0	0	0	0	0	0	0	528	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	2,517	11,672	0	0	0	0	0	0	0	14,189	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(17,456)	0	0	0	0	0	0	0	(17,456)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(17,456)	0	0	0	0	0	0	0	(17,456)	16
	C. General Administration													
17	Administrative	0	0	(127,895)	0	0	0	0	0	0	0	0	(127,895)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,376)	3,500	19,691	0	0	0	0	0	0	0	0	20,815	19
20	Fees, Subscriptions & Promotions	(50)	0	94	0	0	0	0	0	0	0	0	44	20
21	Clerical & General Office Expenses	0	0	69,943	0	0	0	0	0	0	0	0	69,943	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	78	0	0	0	0	0	0	0	0	78	24
25	Other Admin. Staff Transportation	0	0	265	0	0	0	0	0	0	0	0	265	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,258	0	0	0	0	0	0	0	0	1,258	26
27	Other (specify):*	0	0	13,673	0	0	0	0	0	0	0	0	13,673	27
28	**TOTAL General Administration**	(2,426)	3,500	(22,893)	0	0	0	0	0	0	0	0	(21,819)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,426)	3,500	(20,376)	(5,784)	0	0	0	0	0	0	0	(25,086)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(29,223)	209,718	3,549	0	0	0	0	0	0	0	0	184,044	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(110)	264,930	1,170	0	0	0	0	0	0	0	0	265,990	32
33	Real Estate Taxes	0	160,228	3,909	0	0	0	0	0	0	0	0	164,137	33
34	Rent-Facility & Grounds	0	(600,000)	0	0	0	0	0	0	0	0	0	(600,000)	34
35	Rent-Equipment & Vehicles	0	0	1,391	0	0	0	0	0	0	0	0	1,391	35
36	Other (specify):*	0	19,382	0	0	0	0	0	0	0	0	0	19,382	36
37	**TOTAL Ownership**	(29,333)	54,258	10,019	0	0	0	0	0	0	0	0	34,944	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(91,301)	0	0	0	0	0	0	0	0	0	0	(91,301)	43
44	**TOTAL Special Cost Centers**	(91,301)	0	0	0	0	0	0	0	0	0	0	(91,301)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(123,060)	57,758	(10,357)	(5,784)	0	0	0	0	0	0	0	(81,443)	45

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	$	Cahokia Building LLC	100.00%	$ 3,500	$ 3,500	1
2	V	30	Depreciation		Cahokia Building LLC	100.00%	209,718	209,718	2
3	V	32	Interest		Cahokia Building LLC	100.00%	264,930	264,930	3
4	V	33	Real Estate Tax		Cahokia Building LLC	100.00%	160,228	160,228	4
5	V	34	Rent	600,000	Cahokia Building LLC	100.00%		(600,000)	5
6	V	36	Mortgage Insurance		Cahokia Building LLC	100.00%	19,382	19,382	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 600,000			$ 657,758	$ * 57,758	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	S.W. Management Co.	100.00%	$ 45	$ 45	15
16	V	3	Housekeeping		S.W. Management Co.	100.00%	85	85	16
17	V	5	Utilities		S.W. Management Co.	100.00%	1,859	1,859	17
18	V	6	Maintenance		S.W. Management Co.	100.00%	528	528	18
19	V	17	Administrative- Salaries	183,250	S.W. Management Co.	100.00%	55,355	(127,895)	19
20	V	19	Professional Services		S.W. Management Co.	100.00%	19,691	19,691	20
21	V	20	Dues, Fees, Subs & Promotions		S.W. Management Co.	100.00%	94	94	21
22	V	21	Clerical - Salaries		S.W. Management Co.	100.00%	64,420	64,420	22
23	V	21	Clerical & General Office Expense		S.W. Management Co.	100.00%	5,523	5,523	23
24	V	24	Travel and Seminar		S.W. Management Co.	100.00%	78	78	24
25	V	25	Other Admin. Staff Transportation		S.W. Management Co.	100.00%	265	265	25
26	V	26	Insurance-Prop, Liab & Malp		S.W. Management Co.	100.00%	1,258	1,258	26
27	V	27	Mgmt. Allocation of Benefits		S.W. Management Co.	100.00%	13,673	13,673	27
28	V	30	Depreciation		S.W. Management Co.	100.00%	3,549	3,549	28
29	V	32	Interest		S.W. Management Co.	100.00%	1,170	1,170	29
30	V	33	Real Estate Taxes		S.W. Management Co.	100.00%	3,909	3,909	30
31	V	35	Rent-Equipment & Vehicles		S.W. Management Co.	100.00%	1,391	1,391	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 183,250			$ 172,893	$ * (10,357)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$ 4,987	S & E Medical Supply Co.	100.00%	$ 16,659	$ 11,672	15
16	V	3	Housekeeping	14,968	S & E Medical Supply Co.	100.00%	14,968		16
17	V	10	Medical Supplies	31,484	S & E Medical Supply Co.	100.00%	14,028	(17,456)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 51,439			$ 45,655	$ * (5,784)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing and Rehabilitation Center
0039636
12/31/2004

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis
Out-of-State:	
St. Elizabeth Healthcare Center	Florissant, MO

Other Related Business Entities		
S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	3	7.50	Salary	$ 55,355	L17,C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	3.5	8.75	Salary&Fees	65,452	17,3 & 21,7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	4.2	10.50	Salary	17,237	L21,C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 138,044		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Cahokia Nursing and Rehabilitation Center
0039636
12/31/2004
Sheldon Wolfe **Schedule 7A**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	3	$ 55,355		$ 55,355
Caseyville Nursing and Rehab	3	55,355		55,355
Franklin Grove Nursing Center	3	55,355		55,355
Kenwood Healthcare Center	12	221,421		221,421
Oregon Healthcare Center	3	55,355		55,355
Shabbona Healthcare Center	4	73,807		73,807
Tower Hill Healthcare Center	4	73,807		73,807
Virgil Calvert Nursing and Rehab	3	55,355		55,355
St. Elizabeth Healthcare Center	1	18,452		18,452
Other	4	73,807		73,807
	40	$ 738,071		$ 738,071

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing and Rehabilitation Center
0039636
12/31/2004
Ronnie Klein **Schedule 7B**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	3.5	$ 5,452	$ 60,000	$ 65,452
Caseyville Nursing and Rehab	3.5	5,452	60,000	65,452
Franklin Grove Nursing Center	5	7,788	90,000	97,788
Kenwood Healthcare Center	20	31,154	210,000	241,154
Oregon Healthcare Center	3.5	5,452	60,000	65,452
Shabbona Healthcare Center	0	-		-
Tower Hill Healthcare Center	0	-		-
Virgil Calvert Nursing and Rehab	4	6,231	60,000	66,231
St. Elizabeth Healthcare Center	0.5	779		779
Other	0	-		-
	40	$ 62,307	$ 540,000	$ 602,307

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing and Rehabilitation Center
0039636
12/31/2004
Moshe Herman **Schedule 7C**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	4.2	$ 17,237		$ 17,237
Caseyville Nursing and Rehab	4.2	17,237		17,237
Franklin Grove Nursing Center	3.4	13,954		13,954
Kenwood Healthcare Center	8.8	36,115		36,115
Oregon Healthcare Center	2.8	11,491		11,491
Shabbona Healthcare Center	2.5	10,260		10,260
Tower Hill Healthcare Center	5.7	23,393		23,393
Virgil Calvert Nursing and Rehab	4.2	17,237		17,237
St. Elizabeth Healthcare Center	4.2	17,237		17,237
Other	0	-		-
	40	$ 164,160		$ 164,160

SEE ACCOUNTANTS' COMPILATION REPORT

s

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.W. Management Co.
Street Address: 7434 N. Skokie Blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	527,040	9	$ 429	$	54,900	$ 45	1
2	3	Housekeeping	Bed Days Available	527,040	9	820		54,900	85	2
3	5	Utilities	Bed Days Available	527,040	9	17,851		54,900	1,859	3
4	6	Maintenance	Bed Days Available	527,040	9	5,071		54,900	528	4
5	19	Professional Services	Bed Days Available	527,040	9	189,030		54,900	19,691	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	527,040	9	900		54,900	94	6
7	21	Clerical - Salaries	Bed Days Available	527,040	9	566,095	566,095	54,900	58,968	7
8	21	Clerical & General Office Exp	Bed Days Available	527,040	9	53,022		54,900	5,523	8
9	24	Travel and Seminar	Bed Days Available	527,040	9	751		54,900	78	9
10	25	Other Admin. Staff Transport.	Bed Days Available	527,040	9	2,548		54,900	265	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	527,040	9	131,259		54,900	13,673	11
12	32	Interest	Bed Days Available	527,040	9	11,228		54,900	1,170	12
13	33	Real Estate Taxes	Bed Days Available	527,040	9	37,528		54,900	3,909	13
14	35	Rent-Equipment & Venicles	Bed Days Available	527,040	9	13,358		54,900	1,391	14
15	36	Insurance-Prop, Liab & Malp	Bed Days Available	527,040	9	12,072		54,900	1,258	15
16										16
17	17	Administrative - Salaries	Avg. Hours Worked	40	9	738,071	738,071	3	55,355	17
18	21	Clerical - Salaries	Avg. Hours Worked	40	7	62,307	62,307	4	5,452	18
19										19
20	30	Depreciation	Direct Cost						3,549	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,842,340	$ 1,366,473		$ 172,893	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S & E Medical Supply Co.
Street Address: 3100 Commercial Avenue
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 982-9300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 16,659	1
2	3	Housekeeping	Direct Cost						14,968	2
3	10	Medical Supplies	Direct Cost						14,028	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 45,655	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank -HUD		X	Mortgage	$23,524.00	11/27/01	$ 3,961,000	$ 3,859,633	12/01/36	0.0635	$ 246,145	1
2	CCC Note Holders Assoc.		X	Second Mortgage	Varies	11/27/01	265,000	265,000	12/01/36	0.0500	15,365	2
3												3
4												4
5												5
	Working Capital											
6	N/P Stockholders	X		Working Capital				335,442			12,421	6
7		X		Working Capital				Interest on intercompany accounts			20,102	7
8												8
9	TOTAL Facility Related				$23,524.00		$ 4,226,000	$ 4,460,075			$ 294,033	9
	B. Non-Facility Related*											
10							Allocation from SW Mgmt. - Mortgage				1,170	10
11							Amortization of mortgage costs				4,312	11
12							Interest income offset				(110)	12
13							Interest income offset from real estate entity				(892)	13
14	TOTAL Non-Facility Related						$	$			$ 4,480	14
15	TOTALS (line 9+line14)						$ 4,226,000	$ 4,460,075			$ 298,513	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 19,382 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	131,607	1
2. Real Estate Taxes paid during the year: (Indicate the tax yea 14 2003	$	143,835	2
3. Under or (over) accrual (line 2 minus line 1).	$	12,228	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	148,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation		3,909	
TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	164,137	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	118,309	8
2000	115,983	9
2001	120,002	10
2002	125,340	11
2003	143,835	12

Accrual = 2003 Real Estate Tax 143,835 x 1.03 = 148,150

Use - 148,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cahokia Nursing and Rehabilitation Cente COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039636

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-02.0-310-055	Long-Term Care Property	$ 143,835.00	$ 143,835.00
2.	10-28-412-049-0000	SW Management Allocation	$ 38,969.77	$ 3,909.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 182,804.77	$ 147,744.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		2001	$ 230,000	1
2					2
3	TOTALS			$ 230,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		2001		$ 2,928,451	$	15-40	$ 80,744	$ 80,744	$ 250,868	4
5											5
6											6
7	Mgmt.		1995		45,087		39	1,288	1,288	12,437	7
8	Allocation										8
	Improvement Type**										
9	Various			1994	17,847	331	20	1,014	683	12,804	9
10	Various			1995	33,623	337	20	1,681	1,344	16,368	10
11	Various			1996	2,178	56	20	109	53	945	11
12	Various			1997	9,423		20	471	471	3,536	12
13	Various			1998	4,800	123	20	240	117	1,560	13
14	Various			1999	16,265	985	20	813	(172)	4,658	14
15	Air Handler			2000	1,516	175	5	262	87	1,516	15
16	Alarm System			2001	1,908	220	5	382	162	1,741	16
17	Blind			2001	1,212	139	5	242	103	1,106	17
18	Air Handler			2001	1,317		20	66	66	231	18
19	Fan Motor			2001	1,123		20	56	56	173	19
20	Drywall-Dining Room			2002	10,650	273	10	1,065	792	3,018	20
21	Door			2002	9,860	253	20	493	240	1,027	21
22	Air Conditioner			2002	1,198	161	7	171	10	442	22
23	Air Conditioner			2002	1,582	213	7	226	13	584	23
24	Air Conditioners			2002	4,284	576	7	612	36	1,530	24
25	Compressor Air Maxi			2002	1,269	170	7	181	11	483	25
26	Roof - New			2003	97,996	2,513	20	4,900	2,387	8,575	26
27	Nursing Station			2003	35,060	11,219	20	1,753	(9,466)	2,337	27
28	Nursing Station			2003	28,692	9,182	20	1,435	(7,747)	3,109	28
29	Nursing Station			2003	6,368	2,038	20	318	(1,720)	345	29
30	Replace Accelerator			2003	968	39	20	48	9	96	30
31	Sprinkler System			2004	3,610	72	20	90	18	90	31
32	Smoke shelter			2004	6,041	121	20	151	30	151	32
33											33
34	Allocated from SW Management - Leasehold Improvement			1995	4,810		20	241	241	2,662	34
35	Allocated from SW Management - Leasehold Improvement			1996	840		20	40	40	360	35
36	Allocated from SW Management - Leasehold Improvement			1997	1,210		20	61	61	603	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Allocated from SW Management - Leasehold Improvement	1998	$ 833	$	20	$ 42	$ 42	$ 281	37
38	Allocated from SW Management - Leasehold Improvement	1999	2,313		20	116	116	588	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,282,334	$ 29,196		$ 99,311	$ 70,115	$ 334,224	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 799,492	$ 6,871	$ 118,966	$ 112,095	10	$ 450,562	71
72	Current Year Purchases	22,854	1,469	1,542	73	10	1,542	72
73	Fully Depreciated Assets							73
74	Home Office Allocation	11,644		1,157	1,157		9,918	74
75	TOTALS	$ 833,990	$ 8,340	$ 121,665	$ 113,325		$ 462,022	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78	Home Office Allocation	2004 Cadillac	2004	6,038		604	604		604	78
79										79
80	TOTALS			$ 6,038	$	$ 604	$ 604		$ 604	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,352,362	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,536	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 221,580	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 184,044	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 796,850	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 1,783 Description: Copier - 1,783
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19	SW Mgmt. allocation			1,391	19
20					20
21	TOTAL		$	$ 1,391	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	12,571	$ 169,714	$	12,571	$ 169,714	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,835	56,925		1,835	56,925	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		11,703	140,434		11,703	140,434	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				122,795		122,795	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medicare Ambulance	39(3)				1,384			1,384	13
14	TOTAL			$	26,109	$ 368,457	$ 122,795	26,109	$ 491,252	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing and Rehabilitation Center
Provider #: 0039636
01/01/04 to 12/31/04 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
			-	-

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 73,747	$ 190,147	1
2	Cash-Patient Deposits	19,474	19,474	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	1,034,192	1,034,192	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,605	38,801	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	86,059	336,475	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,233,077	$ 1,619,089	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		230,000	13
14	Buildings, at Historical Cost		2,792,742	14
15	Leasehold Improvements, at Historical Cost	162,403	489,592	15
16	Equipment, at Historical Cost	339,474	840,028	16
17	Accumulated Depreciation (book methods)	(290,630)	(796,850)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Net capitalized costs		138,188	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 211,247	$ 3,693,700	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,444,324	$ 5,312,789	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 65,204	$ 71,438	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,382	24,382	28
29	Short-Term Notes Payable	335,442	335,442	29
30	Accrued Salaries Payable	116,443	116,443	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,151	15,151	31
32	Accrued Real Estate Taxes(Sch.IX-B)		148,000	32
33	Accrued Interest Payable	1,211	80,743	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	800,909	549,212	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,358,742	$ 1,340,811	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,124,633	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,124,633	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,358,742	$ 5,465,444	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 85,582	$ (152,655)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,444,324	$ 5,312,789	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Cahokia Nursing and Rehabilitation Center
Provider #: 0039636
01/01/04 to 12/31/04 **Schedule 17A**

XV. Balance Sheet

	Operating	After Consolidation
Line 9 - Other		
Escrow - Insurance	-	12,412
Escrow - Mortgage Insurance Premium	-	186
Replacement Reserve	-	189,871
Escrow - Real Estate Tax	-	47,947
Employee Payroll Advance	85	85
Short-term Loan Exchange	25,000	25,000
Prior Owner Balance	58,417	58,417
Due to Public Aid	2,557	2,557
	86,059	336,475

Line 36 - Other Current Liabilities		
Due to Cahokia Building LLC	251,697	-
Short-term loan exchange	451,447	451,447
Accrued expenses	97,765	97,765
	800,909	549,212

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 243,736	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 243,736	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(158,154)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (158,154)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 85,582	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,428,060	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,428,060	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	298,293	6
7	Oxygen	15,599	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 313,892	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	110	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 110	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,742,062	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	868,140	31
32	Health Care	1,965,409	32
33	General Administration	1,096,995	33
	B. Capital Expense		
34	Ownership	671,842	34
	C. Ancillary Expense		
35	Special Cost Centers	215,480	35
36	Provider Participation Fee	82,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,900,216	40
41	**Income before Income Taxes (line 30 minus line 40)****	(158,154)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (158,154)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,904	2,080	$ 57,511	$ 27.65	1
2	Assistant Director of Nursing	2,024	2,080	52,085	25.04	2
3	Registered Nurses	5,062	5,312	121,100	22.80	3
4	Licensed Practical Nurses	19,958	21,224	395,876	18.65	4
5	Nurse Aides & Orderlies	80,294	84,458	751,485	8.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,369	5,960	70,403	11.81	8
9	Activity Director					9
10	Activity Assistants	6,304	6,726	65,637	9.76	10
11	Social Service Workers	1,623	1,791	27,071	15.12	11
12	Dietician					12
13	Food Service Supervisor	1,751	1,981	25,752	13.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,290	19,719	167,139	8.48	15
16	Dishwashers					16
17	Maintenance Workers	2,799	2,903	35,726	12.31	17
18	Housekeepers	17,224	18,222	133,997	7.35	18
19	Laundry	8,363	8,799	57,650	6.55	19
20	Administrator	1,944	2,080	118,807	57.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,292	16,471	279,268	16.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	188,201	199,806	$ 2,359,507 *	$ 11.81	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 3,600	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	425	5,744	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	425	$ 20,344		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	96	2,118	L10, C3	52
53	TOTAL (lines 50 - 52)	96	$ 2,118		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Robin Suidan	Administrator		118,807
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,807

B. Administrative - Other

Description	Amount
SW Management	$ 183,250
Ronnie Klein	60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 243,250
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg & Rothblatt	Accounting	$ 14,247
Personnel Planners	Unemployment consultant	1,522
Winston & Strawn	Legal	3,412
Ashman & Stein	Legal	4,325
Tueth, Keeney, et.al.	Legal	35,371
Capes, Soka, Goodman	Legal	2,842
Sachnoff & Weaver	Legal	4,026
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 65,745

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,802
Unemployment Compensation Insurance	52,974
FICA Taxes	178,586
Employee Health Insurance	31,701
Employee Meals	3,012
Illinois Municipal Retirement Fund (IMRF)*	
Employee Morale	1,243
TOTAL (agree to Schedule V, line 22, col.8)	$ 320,318

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,500
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 165)	1,640
Illinois Council for Long-Term Care	4,050
Miscellaneous dues & subscriptions	330
Miscellaneous permits & inspections	550
Miscellaneous dues	709
Allocated from Home Office	94
Less: Public Relations Expense	(50)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,823

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached	1,638
Allocated from Home Office	78
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,716

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Cahokia Nursing and Rehabilitation Center
Provider #: 0039636
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	65,745
Allocated from Cahokia Building LLC - Accounting	3,500
Allocated from Management Company - Legal	18,983
Allocated from Management Company - Accounting Frost, Ruttenberg & Rothblatt	708
Less: Non-allowable legal expenses	(2,376)
Total (agree to Schedule V, line 19, column 8)	86,560

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3			N/A										
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cahokia Nursing and Rehabilitation Center # 0039636 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long-Term Care - 4,050**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **N/A** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **82,350**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **3,012** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	192,891	15,463	3,600	211,954	0	211,954	0	211,954
2. Food Purchase	0	159,595	0	159,595	0	159,595	8,705	168,300
3. Housekeeping	133,997	66,420	0	200,417	0	200,417	85	200,502
4. Laundry	57,650	23,434	0	81,084	0	81,084	0	81,084
5. Heat and Other Utilities	0	0	110,809	110,809	0	110,809	1,859	112,668
6. Maintenance	35,726	59,080	9,475	104,281	0	104,281	528	104,809
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	420,264	323,992	123,884	868,140	0	868,140	11,177	879,317
9. Medical Director	0	0	4,800	4,800	0	4,800	0	4,800
10. Nursing & Medical Records	1,448,460	32,749	8,318	1,489,527	0	1,489,527	-4,726	1,484,801
10a. Therapy	0	0	372,817	372,817	0	372,817	0	372,817
11. Activities	65,637	5,557	0	71,194	0	71,194	0	71,194
12. Social Services	27,071	0	0	27,071	0	27,071	0	27,071
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,541,168	38,306	385,935	1,965,409	0	1,965,409	-4,726	1,960,683
17. Administrative	118,807	0	243,250	362,057	0	362,057	-127,895	234,162
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	65,745	65,745	0	65,745	20,815	86,560
20. Fees, Subscriptions & Promotion	0	0	9,779	9,779	0	9,779	44	9,823
21. Clerical & General Office	279,268	0	39,174	318,442	0	318,442	69,943	388,385
22. Employee Benefits & Payroll	0	0	317,306	317,306	0	317,306	3,012	320,318
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	1,638	1,638	0	1,638	78	1,716
25. Other Admin. Staff Trans	0	0	5,196	5,196	0	5,196	265	5,461
26. Insurance-Prop.Liab.Malpractice	0	0	16,832	16,832	0	16,832	1,258	18,090
27. Other (specify)*	0	0	0	0	0	0	13,673	13,673
28. Total General Adminis	398,075	0	698,920	1,096,995	0	1,096,995	-18,807	1,078,188
29. Total General Administrative	2,359,507	362,298	1,208,739	3,930,544	0	3,930,544	-12,356	3,918,188
30. Depreciation	0	0	37,536	37,536	0	37,536	184,044	221,580
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	32,523	32,523	0	32,523	265,990	298,513
33. Real Estate	0	0	0	0	0	0	164,137	164,137
34. Rent - Facility & Grounds	0	0	600,000	600,000	0	600,000	-600,000	0
35. Rent - Equipment & Vehicles	0	0	1,783	1,783	0	1,783	1,391	3,174
36. Other (specify):*	0	0	0	0	0	0	19,382	19,382
37. Total Ownership	0	0	671,842	671,842	0	671,842	34,944	706,786
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	122,795	1,384	124,179	0	124,179	-12,730	111,449
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	82,350	82,350	0	82,350	0	82,350
43. Other (specify):*	0	0	91,301	91,301	0	91,301	-91,301	0
44. Total Special Cost Ce	0	122,795	175,035	297,830	0	297,830	-104,031	193,799
45. Grand Total	2,359,507	485,093	2,055,616	4,900,216	0	4,900,216	-81,443	4,818,773

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	73,747	190,147
2. Cash - Patient Deposits	19,474	19,474
3. Accounts & Notes Recievable	1,034,192	1,034,192
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	19,605	38,801
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	86,059	336,475
10. Total current assets	1,233,077	1,619,089
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	230,000
14. Buildings, at Historical Cost	0	2,792,742
15. Leasehold Improvements, Historical Cost	162,403	489,592
16. Equipment, at Historical Cost	339,474	840,028
17. Accumulated Depreciation (book methods)	-290,630	-796,850
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	138,188
23. other (specify):	0	0
24. Total Long-Term Assets	211,247	3,693,700
25. Total Assets	1,444,324	5,312,789
CURRENT LIABILITIES		
26. Accounts Payable	65,204	71,438
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	24,382	24,382
29. Short-Term Notes Payable	335,442	335,442
30. Accrued Salaries Payable	116,443	116,443
31. Accrued Taxes Payable	15,151	15,151
32. Accrued Real Estate Taxes	0	148,000
33. Accrued Interest Payable	1,211	80,743
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	800,906	549,209
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,358,739	1,340,808
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	4,086,332
40.Mortgage Payable	0	38,301
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	4,124,633
46.Total Liabilities	1,358,739	5,465,441
47.Total Equity	85,585	-152,652
48.Total Liabilities and Equity	1,444,324	5,312,789

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	4,428,060
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	4,428,060
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	298,293
7. Oxygen	15,599
Subtotal - Anciliary Revenue	313,892
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	110
Subtotal - Non-Operating Revenue	110
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	4,742,062
31. General Services	868,140
32. Health Care	1,965,409
33. General Administration	1,096,995
34. Ownership	671,842
35. Special Cost Centers	215,480
35. Provider Participation Fee	82,350
37. Other	0
40. Total Expenses	4,900,216
41. Income Before Income Taxes	-158,154
42. Income Taxes	0
43. Net Income or Loss for the Year	-158,154